NHS
Surrey Heartlands

Non-Subcutaneous Alternative Medications for Symptom Control in Terminal Care

Aim

To provide medication alternatives for symptom control in those judged likely to have a low burden of need who are likely to be approaching the terminal phase of dying within the next few months or less.

Background

There has been a recognised need for those in non-nursing community environments e.g.: private domicile, residential homes and sheltered accommodation, who have been recognised as dying of an expected illness for whom best supportive care is felt to be the best approach. In this group it has been noted that providing sub-cutaneous (SC) medications and the nursing support to deliver these medications is often challenging and a lack of resources to provide timely responses to patient symptoms control may lead to avoidable admission to hospital and consequent management of dying in hospital where this wasn't the elected preferred place of death.

Many of these patients require relatively little therapeutic management to help ensure comfortable dying is achieved in their preferred place of death. However, at present there is no regional provision for standardised alternatives to SC medications. An additional benefit to the provision of alternative medications to the current standard of SC injectables is the improvement in untrained carer confidence when managing the symptoms associated with normal dying.

SC medications remain the gold standard for management of symptoms in dying and if possible, should still be prescribed in situations where needed. This guideline is written to provide alternatives to SC medications to address the above need. Double prescribing both SC and alternatives to SC medications is not recommended although a tailored approach using these medications may be reasonable.

N.B. These guidelines do not replace local practices but are aimed to supplement community based prescribing and provide support to carers, for patients in the last part of their life, whose wish is to remain at home or in a residential home.

Patient criteria

This is for patients in whom dying has been explicitly recognised and documented and who have short months or less to live. The administration of these medications is recommended only when all likely reversible or other therapeutic options are not felt to be possible or are likely futile. Some patients will elect to limit their care to best supportive care options despite potential life extending therapies being offered, if this is the case and agreed as a reasonable approach in the context of a life limiting disease then this guideline is likely to be appropriate to support prescribing in these circumstances too. If SC anticipatory medications would be appropriate then it is likely that these alternatives are also appropriate.

A completed ReSPECT plan acknowledging that dying has been recognised and a best supportive care approach has been agreed with the patient and next of kin should be present and updated on all relevant systems.

This is designed for people in non-nursed settings. It is NOT appropriate for patients in hospice, nursing home or hospital/community hospital settings, where use of SC medications should be the expected route of administration.

This is not suitable for patients who are on long term opioids and/or complex pain regimes. We recommend patients who fit that picture are discussed with local hospice and palliative care teams to ensure appropriate anticipatory prescribing and monitoring is in place.

Carer criteria

- Age over 18
- Able to give consent to administer
- The patient has agreed that the carer give the medication or otherwise agreed under a best interest decision
- Are they aware that when administering medications to a dying individual death can occur in proximity to the administration of medicines? The two events are not expected to be linked in any fashion but awareness that this can happen is recognised to be important
- Not suffering from any form of addiction to any of the substances being prescribed

Carers should be individually screened by the prescriber or trusted assessor who is content to sign against the carer guideline for administration that the carer(s) is capable of safe administration, understands the guideline and is content to administer the medication as prescribed. See Appendix 1 for carer guidelines.

Medication

Indication	Medication	Dose	Additional Information
Agitation/ Restlessness	**1st line** Diazepam 5mg/2.5ml rectubes OR Lorazepam 1mg tablets	5mg up to twice daily PRN 0.5mg-1mg SL QDS (MAX 4mg in 24 hours)	Lorazepam: The Actavis® brand of lorazepam does not dissolve well sublingually and is not scored making it difficult to give a 0.5mg dose. It is therefore preferable to use the blue, scored GENUS®, PVL® or TEVA® brands which are more practical to use. Should be prescribed as: "Lorazepam sublingual 1mg "to ensure that the patient receives the appropriate product.
	2nd line Olanzapine 5mg orodispersible tablets	5mg up to one every 12 hours	Olanzapine orodispersible 5mg tablets (place on tongue or buccal membrane) Do not give in known Parkinson's disease if receiving dopamine containing medication.
Pain and/or breathlessness	**eGFR> 30** Morphine 10mg/5ml oral solution	2-4mg up to every 2 hours PRN. MAX 6 doses in 24 hours	Always start at lowest recommended dose before increasing to second step. Morphine oral solution 10mg/5mls. Intermittent dosing is appropriate if breathlessness is not continuous. This dose is only for opioid naïve patients – for non-opioid naïve patients please seek specialist advice.
	eGFR< 30 Oxycodone 5mg/5ml oral solution	1-2mg up to every 2 house PRN. MAX 6 doses in 24 hours	Always start at lowest recommended dose before increasing to second step. Oxycodone oral solution 5mg/5mls. This dose is only for opioid naïve patients – for non-opioid naïve patients please seek specialist advice.
	2nd line Morphine orodispersible tablets (Actimorph®)	2-4mg up to every 2 hours PRN. MAX 6 doses in 24 hours	Can be considered as an option if there is a high risk of aspiration. This dose is only for opioid naïve patients – for non-opioid naïve patients please seek specialist advice.

Excess respiratory secretions	Hyoscine Hydrobromide 1mg/72 hours transdermal patches	1mg every 72 hours – apply one patch to the side of the neck, alternate sides after 72 hours. Apply up to 2 patches at any one time.	Caution in delirium as may worsen symptoms of delirium.
Nausea/ Vomiting	**1st line** Olanzapine 5mg orodispersible tablets	5mg up to one every 12 hours	Olanzapine orodispersible 5mg tablets (place on tongue or buccal membrane) Do not give in known Parkinson's disease if receiving dopamine containing medication. **This is an off-label use of olanzapine.**
	2nd line Prochlorperazine 3mg buccal tablets	3-6mg up to twice daily. Tablets to be placed high between upper lip and gum and left to dissolve	Do not give in known Parkinson's disease if receiving dopamine containing medication.

- Renal failure – eGFR <30 but greater than 10 – use oxycodone as first line opioid and halve all doses of other medications where feasible.
- eGFR <10 reduce oxycodone frequency to 4 hourly and where possible reduce frequency of all other medications.
- Severe liver failure/cirrhosis use morphine at half dose as first line opioid and halve all other medication doses.

Appendix 1

Carer guidelines for administration of medicines to a person who is dying

Medicines for a person who is approaching death in the next few days or hours
A person who is dying may experience symptoms as part of the normal dying process. These symptoms may be distressing. There are some medicines which may help with these symptoms and can be given to improve the comfort of the dying person if they are needed. If you have any questions or concerns about giving these medicines, please discuss this with the prescriber or health care professional.

Some common symptoms and their treatments are listed below:

Pain or Breathlessness
A person who is dying may not be able to say that they are in pain, but there may be signs that indicate pain - for example grimacing, holding an area of the body, crying out or bringing the knees to the tummy.
If the person is in pain, a painkiller can be given as an oral solution. **Morphine** or **oxycodone** are liquids and the dose to be given will be on the label of the bottle, as well as how often you can give it. Even if the person is not fully alert, it is usually fine to give them a very small amount into their mouth. If possible, the person should be sat up in bed with their head supported whilst you give the medicine.
If you are concerned about the risk of the liquid medication causing coughing or choking, then we advise calling your local hospice for support and considering using a relaxant medication such as **diazepam** or **lorazepam** as these may also help with pain.
If there is a high risk of choking, the GP may prescribe **Actimorph® tablets**. These can be placed on the tongue, and allowed to disperse. Alternatively, the tablets can be placed on a spoon and dispersed in a small amount of water before administration. One dose is likely to last for 3 to 4 hours and it may be repeated after 2 hours if the first dose wasn't enough. We recommend no more than 6 doses in 24 hours. If you are giving 3 or more doses, please call your GP or local hospice or district nurse to let them know.

Nausea
If the person feels sick (nausea) or vomits, **olanzapine orodispersible tablets** can be given. These are not to be swallowed but should be placed behind the lip against gums and the front or side teeth or under the tongue. One dose is likely to last for 8 hours or longer. Please note that although **olanzapine** is off-label* for use in nausea, it is the most useful and effective medicine to use when given for nausea to a person who is dying. *Off-label use means that the manufacturer of the medicine does not have a licence for this use, but the product is licensed for other conditions. **Olanzapine** may also be given after or instead of **diazepam** to help calm a person.
An alternative medicine that can be given if the person feels sick or vomits is **prochlorperazine buccal tablets**. These tablets are not swallowed and should be placed high between the upper lip and gum and left to dissolve. These can be given up to twice a day.

Restlessness or agitation
If the person who is dying is restless or agitated, there are several things which may help to make the person calmer, such as talking or music, adjusting the temperature of the room or using fans. However, when these adjustments are not enough, **diazepam rectubes** (suppositories) can be used. This will calm the person and may make them more sleepy. One dose may last for 24 hours, and a second dose can be used after two hours if one dose doesn't help. No more than two should be used in 24 hours. The rectubes are used rectally, by inserting into the bottom. This means that if the person who is agitated is not keen on taking tablets, then **diazepam** can be used safely. If you feel unsure about using a suppository then please let your GP know as alternatives are available**.** Alternatively, if the person is able to place a tablet under the tongue, **lorazepam sublingual tablets** may be given 4 times a day instead of **diazepam**.

Excess secretions in the chest or throat (death rattle)
As part of the process of dying, normal activities like coughing and swallowing the saliva at the back of the throat don't happen as much. When the saliva sits at the back of the throat it may make a loud noise. The person experiencing this is unaware of it, and it doesn't appear to bother them. Try gently moving the person to sit or lie on a different side. This may help the saliva to move away from where it is, and the noisy breathing reduces. If this isn't possible or doesn't help, then a **hyoscine hydrobromide patch** can be placed on the person's neck. This should help to reduce the noisy breathing. The patch should work for about three days before needing to be changed.

Concerns and questions
If you have any concerns or questions, please do not hesitate to contact your GP, local hospice or district nurse.

Additional resources
Scenario: Symptomatic treatment | Management | Palliative care - dyspnoea | CKS | NICE
Off-label or unlicensed use of medicines: prescribers' responsibilities - GOV.UK (www.gov.uk)

Contact details:

GP:_____

District Nursing Team:_____

Hospice Team:_____

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Agreed by: *Surrey Heartlands Integrated Care System Area Prescribing Committee – February 2024*

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